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ABSTRACT

This study was conducted to identify efforts by hospital discharge planners to refer clients with human immunodeficiency virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) to nursing homes; to determine the responses of the facilities contacted; and to identify gaps in services, discharge planner practices, and relationships between characteristics of clients, care systems, and outcomes. Discharge planners in hospitals with the highest incidence of patients with HIV infection in Chicago were contacted bi-monthly to provide information on persons with AIDS who needed to be discharged from the hospital with post-hospital continuing care provision. Questionnaires requested information on demographics, diagnoses, care needed, placement, and number of days hospitalized beyond a medical need. The results revealed that, in a 3-month period, none of the 42 identified clients were admitted to any nursing home. One-fifth of the cases included referral to multiple facilities. Total placement contacts and admissions that did occur were in specialized AIDS residences. Patients were assessed as staying in the hospital for 8 days beyond acute care needs. These findings suggest that difficulties in placing persons with AIDS in care facilities have financial and quality of life costs. Long-term care of persons with AIDS must be a coordinated effort throughout the care continuum including governmental agencies, health care and social workers, and the long-term care industry. (Author/NB)

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Assessment of Discharge Planning Referral to Nursing Homes for People with AIDS and HIV Infection

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Abstract

Objective: Survey hospital discharge planners to identify efforts to refer clients to nursing homes and to determine the responses of the facilities contacted; identify gaps in services, discharge planner practices, relationships between characteristics of clients, care systems, and outcomes. **Methods:** Discharge planners in hospital with highest incidence of HIV in Chicago were contacted bi-monthly to provide information on PWAs who needed discharge from the hospital with post-hospital continuing care needs. Questionnaire included demographic, diagnostic, care needed, and placement information and days hospitalized beyond medical need. **Results:** In three month period, none of the 42 identified clients were admitted to any nursing home. A fifth of the cases included referral to multiple facilities., Total placement contacts and admissions that did occur were in specialized AIDS residences. Patients were assessed as staying in hospital a medium of 8 days beyond acute care needs. **Conclusions:** Difficulties in placing PWAs in care facilities have financial and quality of life costs. Long-term care of PWAs must be a coordinated effort throughout the care continuum including governmental agencies, health care and social workers, and the long-term care industry.

Facing Nursing Home Resistance in Discharging Planning for People with HIV Infection

An array of long-term care services are increasingly needed in continuing care of People with AIDS (PWAs). AIDS and related HIV spectrum disease is increasingly viewed as comprising a chronic disease sequence, especially with the advent of anti-viral and interventive medications (eg. AZT, aerosolized pentamidine). Illnesses related to HIV, the virus associated with AIDS, are often expressed in a sequence of acute episodes which may signal the need for one or more periods of supervised care. Many future PWAs will live longer than their predecessors, with both episodic and extended continuing care and rehabilitation needs. As the health care industry gains more experience providing care for PWAs, long-term care facilities will increasingly be called upon to play a more substantial role.

AIDS has presented a challenge to the long-term care continuum, resulting in reliance on existing models as well as the development of new approaches. While home-based community care is seen as the ideal when necessary resources can be assembled, a substantial sub-population of people with HIV related illnesses require ongoing care that cannot be provided at home. To date there is no universal method for projecting the need for long-term care services; current estimates range from 10-25 per cent of all living cases may require this type of care (Holland & Conley, 1988; King County Department of Health, 1987; Lawler, 1987) and the percentage of PWAs requiring nursing-home type care is often estimated at 10%. Afzal and Wyatt (1989) describe several reasons for placing a PWA in a long-term care facility. They

state that:

> like other long-term care patients, PWAs require care in an institutional setting where their functional disability, social circumstances and available resources require it. Virtually anyone can be cared for at home if the patient has the financial resources and a friend or family member willing to help give care (p. 20-21).

They further cite several categories of PWAs that may be better suited to nursing home than home care:

- when AIDS related dementia has progressed to a point where they cannot be self directing and have no friends or relatives available to help them
- when the stress of caring for the patient combines with other factors to make home care overwhelming for family or friends
- when homelessness or inadequate housing may be factors in determining the need for institutional care (Afzal & Wyatt, 1989, p. 21).

Community-based residential options, where nursing needs may be provided for by volunteers or home care agencies, are developing in both large and medium sized population centers. However, often there are no alternative settings outside of the high cost hospital available to persons with AIDS (Adams, 1989; Afzal & Wyatt, 1989; Beresford, 1989; Gillis, 1987; Mantell, Shulman, Belmont & Spivak, 1989; Nelson & Reimann, 1988; Wyatt, 1987).

Studies of discharge planners, community service workers, and nursing homes have found that nursing homes are reluctant to open their doors to the AIDS affected population. Discharge planners throughout the country have expressed frustration with the lack of placement options for PWAs in need of continuing care. A study of

New York City's St. Lukes Hospital found that 48% of patients seen by social workers had a discharge planning problem, which predominantly was a lack of community, residential or home care options. Researchers concluded that the "lack of appropriate care facilities and unwillingness of skilled nursing, chronic and terminal care facilities to provide beds for people with AIDS were major obstacles in the discharge of patients" (Mantell et al., 1989, p.45).

Studies of attitudes and actions of nursing home employees and administrators reflect this reticence toward PWA admissions (Cich & Linsk, 1989; Engstrom, 1987; Moreau & Panfil-Glick, 1986; Wisconsin AIDS Update, 1988). In an Illinois study nursing home employees were found to have negative attitudes toward PWAs with 46% feeling that hospitals and nursing homes should be able to refuse to admit PWAs (Sarvela & Moore, 1989).

Placement difficulties often lead to unnecessarily long hospital stays for PWAs. Studies suggest that 10 - 36% of PWAs in hospitals could have been cared for in a less specialized setting if one were available (Luehrs, Orlebeke & Merlis, 1986; Peterman & McCormick, 1988; Holland & Conley, 1988; San Francisco Department of Public Health, 1989). These unnecessary hospital stays are not only a costly way to respond to the lack of long-term care for PWAs but subject patients to risks of further infection and neglect the psychosocial needs of the patient (Engstrom, 1987).

Our efforts grew out of a mutually perceived need for attention to the long-term care needs of PWAs as experienced by a 70 member consortium of service agencies in Chicago. A committee was established to study the long-term care situation and advocate for needed changes under auspices of the AIDS Foundation of Chicago. Efforts include conducting a two-pronged survey which looked at the nursing homes of Illinois and their response to the AIDS epidemic as well as the experiences of

hospital discharge planners in placement of PWAs after hospitalizations.

An initial study (Cich & Linsk, 1989) demonstrated that virtually no Illinois nursing homes accept AIDS patients and that discharge planners were so discouraged that they were reluctant to continue to pursue nursing home placements. In fact, fewer referrals were being made than anticipated and the nursing homes perceived less demand for care than was actually present. In short the referrers and the recipients of referrals were not working together. These results led the committee to embark on a comprehensive educational strategy to reach the general public, nursing home administrators, hospital discharge planners and relevant state departments.

A second exploratory study was undertaken to examine more carefully the experience of discharge planners, to determine the process of discharge planning for these patients and to examine relationships between characteristics of clients, care systems, and outcomes. This article documents these discharge planners' experiences with PWAs in need of long-term care during a three month period in the Spring and Summer of 1989 in Chicago. The survey was designed to take an inventory of the persons requiring care, the facilities contacted by discharge planners and the facilities response to the referrals. The study was constructed to document gaps in services, discharge planner practices, and consequences for clients.

Method

Hospital participation:

Researchers contacted hospital social work departments in Chicago hospitals serving the largest proportion of people with AIDS in order to identify discharge planners willing to serve as contact points in tracking discharge activities for patients with AIDS. Ten social workers at seven hospitals in the Chicago area provided information about their clients with HIV infection from April to June of 1989.

Workers were contacted twice a month to provide information on PWAs who were discharged from the hospital and had required housing and post-discharge continuing care, as well as patients that should have been discharged but remained in the hospital because an appropriate placement was unavailable. Recognizing that discharge planners were extremely busy, we limited our scope by looking only at patients whom a worker had identified as in need of a long-term care or residential placement. Even with this change however, one discharge planner did not provide data for the month of June.

The large inner-city county hospital with three participating workers supplied 31% of the client data. Workers at five private hospitals within the geographic area that has the highest incidence of AIDS provided 54% of the data. A hospital with an active AIDS treatment evaluation unit supplied data on only one patient (2.4%). Similarly, the remaining hospitals provided only a few cases.

All of the discharge planners were MSW's with varying degrees of experience ranging from less than one year to five years of working with PWAs.

Instrument

A short questionnaire with both open-ended and forced choice questions was designed to track PWAs in the following areas:

1. Demographic information: age, sex race and high risk behavior;
2. Diagnoses and care needs: physical conditions and care needs of patients whose workers designated them as in need of long-term care;
3. Facility and placement information: facilities contacted, facility response, patient outcome and the workers' assessment of the appropriateness of the outcome; and
4. Days hospitalized beyond medical need.

Data analysis consisted of frequency compilation and descriptive statistics. Open ended questions were content sorted by theme, coded and analyzed accordingly. Contingency tables were developed to compare variables of interest and tests conducted to determine statistical significance.

Findings

Patient information:

Forty-two patients were tracked over the three month period. Patient profiles compared to overall Chicago statistics are presented in table 1. The patients' ages range from 20 to 58, with a modal age of 32 and an average age of 35.6. A quarter of the patients were age 40 and older. Ninety-one percent of the patients were male with only four females in the survey. Forty-three percent of the patients were African-American, 38% White, and 20% Hispanic. Greater percentages of minorities were present in the sample than the total reported adult AIDS cases in Chicago during the same three month period (see table 1). African-American representation was 15% higher and Hispanics were 9% higher than total Chicago reported cases.

Insert Table 1 here

The majority (70%) of the sample engaged in male to male sex and 30% were described as IV drug users. Six percent of the drug users had sexual relations with an infected partner and 17% of those who engaged in male to male sex also used IV drugs. The IV drug use incidence of the sample is double the Chicago total for the same period (see table 1). This may relate to the higher percentages of minorities contracting AIDS from IV drug use and the higher percentage of minorities in the

sample. No transfusion blood product (for hemophilia) or heterosexual transmission cases were reported. Thirty-eight percent of the African-American and 50% of the Hispanics in the sample were described as at risk for HIV due to needles use, while only 13% of the whites having a similar risk, due to IV drug use.

Most of the patients (68%) received Medicaid, 22% had private insurance and the remainder were either self-pay or Medicare.

Patient diagnoses and care needs:

Patients were hospitalized with a variety of different ailments (see table 2). A third were diagnosed with pneumocystis carninii pneumonia, about a fifth each had neurological problems or wasting syndrome and about a sixth had Kaposi's sarcoma. Patients were identified as needing a variety of post-hospital care. Almost a third each required I.V. therapy, nutritional care, or care related to incontinence. About one in six required post-hospital respiratory care and one in ten required wound care. With regard to mental status, forty-one percent of the patients were alert and oriented, over a third were occasionally confused, one patient was reported as unconscious while five were described as lethargic. Two-thirds did not have any behavioral problems.

Insert Table 2 here

Workers were asked to assess the patient's care requirements for discharge (see table 3). About a third each were assessed as needing a skilled care facility or an intermediate care facility, while over a fifth required a sheltered residential service. An additional 7% were only in need of housing in order to be discharged and one patient died before assessment.

The reasons for these assessments varied, all of them were based on medical requirements that could be satisfied in these facilities. Psycho-social aspects were also assessed such as the strength or weakness of the patient's social support system. For some patients, the immediate care needs were too intense for family members. Workers indicated that if patients could reside at a facility until their conditions stabilized family members then would be able to care for the patient once discharged from a long-term care facility. In other cases, the patients' parents were themselves elderly and sometimes frail and unable to cope with the care needs of a sick child. One worker found it necessary to make a placement referral to a nursing home for the parents of a patient as well as trying to find appropriate long-term care for their son.

Insert Table 3 here

Facility and placement information:

Workers were asked which facilities were contacted in attempts to place the patient. Two thirds of the workers contacted only one facility. In a fifth of the cases the worker contacted two or more facilities. In about 1/6 of the cases workers expressed frustration with the lack of options available to their patients and reported that because of the lack of resources they did not make any placement attempts.

Total placement contacts, referral or inquiries were found to be the greatest at specialized AIDS residences which provided housing, some supervision and support services. While these facilities did not provide nursing care directly, it was possible to arrange for home care agencies within the setting. In over half of the cases the worker contacted at least one specialized AIDS residence. In a quarter of the cases

the county long-term care facility with four designated beds for PWAs was contacted and an emergency shelter program was called for 21% of the PWAs. Nursing homes were called for placement information for 18% of the clients, as were residential hotels.

In the cases where multiple placement attempts were made, workers called between two and 5+ facilities trying to find an appropriate placement. One relatively new worker to the field (hired one month into the study) contacted ten nursing homes, all of which refused to admit the patient. Most of the facilities indicated that they had no available beds and one home went so far as to say they had violations with the board of health and could therefore not admit a PWA.

A relationship emerged between the number and types of contacts to different facilities and the years working as a discharge planner with PWAs. Workers newer to the field were more willing to try multiple contacts in their placement attempts than workers who had been in the field four years or more. However, the more experienced workers were more able to move further toward successful placements, suggesting that the newer workers worked harder with poorer results. Experienced workers were twice as likely to complete the application to wait-list status and twice as likely to successfully place the clients in a residential setting. This suggests that the more experienced workers spent less time calling resistant nursing homes while focusing their limited time on placement attempts at residences with a track record of admitting PWAs.

Outcomes after hospital stay

All of these contacts proved to be unsuccessful in making a nursing home placement (See table 4). None of the patients referred to the county facility with the only designated beds in the state were admitted during the study period. The county

home wait-listed 88% of the patients and for the other 12%, a referral was made and the discharge planner or the facility did not take any further action. Half of these patients who were referred to the county facility died or remained in the hospital. The other half were placed in a sheltered residence (25%) or returned home (25%).

Insert Table 4 here

Similar experiences were found with other nursing home referrals. None of the patients referred to nursing homes were admitted. Of those referred to nursing homes on the first placement attempt, 42% remained in the hospital, 25% went home 16% each died in the hospital or entered a sheltered residence.

In all, almost one quarter of the patients returned home, or to the home of a relative or friend, or home with supportive services. A little over a fifth remained in the hospital, while close to a fifth died in the hospital while waiting for a placement option to become available. Only seventeen percent of the patients were placed in a specialized AIDS residence and ten percent left the hospital against medical advice (see table 3).

When workers were asked if in their opinion, was this the best outcome for the patient only 29% responded affirmatively, 38% felt it was not the optimal outcome, and in a third of the cases the patient had died or there was no worker statement concerning the outcome.

Number of days in hospital:

Hospital stays ranged from one day to a little over two months. Fifty percent of the stays were for eleven days or less with an average stay of 15 days. Workers were asked how many days beyond acute care need were patients in the hospital

because of placement difficulties (this was measured by indicating the number of days the client remained in the hospital after the placement procedure began). In 61% of the cases workers indicated that patients were staying 2 to 32 days over their acute care needs. The average overstay was 8 unnecessary days. In aggregate, the days represent 304 person days in a three month period which could have been spent in a less intensive setting.

Discussion

This exploratory study describes the actions of a limited number of workers with an opportunity sample during a discrete period. Generalizability for this sample is cautionary as trends are likely to be understated in the findings. The time limitations of these workers generated by their active caseloads made it difficult to assure that all of the population was reported during the time period. Despite the methodological limitations, these findings do fill a major gap in information about critical practice issues affecting continuing care for this complex service population. Because of the day-to-day problems in discharge planning, a more controlled investigation was logistically not possible. The present study offers the advantages that a diverse sample of cases were tracked in multiple settings over a designated time period, and includes the flavor of the practice problems in these very active hospital settings. It appears that the findings do suggest relevant trends in the area of AIDS and access to long-term care.

Patients with AIDS related illnesses who need nursing home care are in a tenuous position. They not only face their own physical atrophy but also the failure of the long-term care system to respond to their needs. This study documents the need of PWAs for nursing home care as well as the lack of available placement options. Even within the AIDS residential service sector, many more referrals are being made

than can be accommodated.

Hospital social workers, frustrated by a lack of residential placement options, spend a great deal of their limited hours making futile calls to facilities known to be unresponsive, or in many cases not bothering, as one worker put it, to "knock my head up against a wall" by making ineffectual referrals. These findings point to extreme job stress and frustrations felt by these workers. They tended to experience high case loads and face daily resistance from institutions within the long-term care industry. The results suggest that job related stress, burnout and attrition are major concerns for social workers involved in AIDS related care, especially discharge planning of those with housing or continuing care issues. Clearly the workers are distressed by this situation as the majority of the workers in this study did not feel that they had attained the best outcome for their patient's placement. The findings suggest the need to continue study of services to persons with HIV infection. As more experienced workers were more efficient in efforts to locate services, we might question whether resources and service linkage models are adequately articulated to beginning workers, who often have responsibility for discharge planning. On the other hand, the more efficient efforts by experienced workers precluded calls to nursing homes thus limiting the pressure on nursing homes to respond to the needs of PWAs.

The combination of a lack of placement options and limited time for designing placement plans engenders a systemic failure whereby the nursing homes, already reticent to accept PWAs, are not experiencing the full impact of the demand for their services. It is in the interest of the nursing home industry to aggressively respond to this demand for a number of reasons. First, the industry has a moral imperative to open its doors to PWAs. Long-term care facilities are an appropriate placement option and PWAs have a right to obtain this service. The facilities have the technical support

to care for those in need of temporary stabilization after an acute episode, and to care for those who have chronic conditions related to the disease. Second, the nursing home industry has a legal obligation to provide care for PWAs. Discrimination against patients based on the diagnosis of AIDS is illegal under section 504 of the Rehabilitation Act of 1974. Compliance can be enforced by, among others, the U.S. Office of Civil Rights of the Department of Health and Human Services. Social workers, families or friends of PWAs can also seek help in gaining access to discriminatory homes by contacting local legal advocacy resources. Nursing homes that discriminate face the risk of both legal prosecution and financial withdrawal of state and federal funds. Third, there is the distinct possibility that within the nursing home population, some residents as well as staff may well be infected with HIV and may develop symptoms. Nursing homes cannot afford to be blind to this fact and should assertively train staff in both universal precautions and care techniques to reduce risk, fears and address misunderstandings. Fourth, nursing homes who do admit PWAs have an opportunity to become innovators in their fields and to gain recognition for providing care for those in need.

Gaining access to nursing homes must be exercised in concert with a concern for the quality of care in these institutions. Nursing home staff require education for both responses to the physical care needs, infection control as well as to be sensitive to the psycho-social needs of this new client population. Facilities should make a commitment to provide quality services and invest the time and resources required to adequately train and emotionally prepare staff, residents, and their families. Structural systems are needed to address pragmatic issues that arise when PWAs are cared for in settings that include other populations such as elderly patients. Concurrent with this effort should be the creation of more specialized residential

facilities for PWAS. These settings can meet the care needs of PWAs in a hospitable environment. With the advent of AZT and other pharmaceutical advancements in the treatment of viral and bacterial infections, the need for facilities that can care for chronic conditions will most likely be on the rise. It is imperative that both specialized settings and geriatric nursing homes work in concert to respond to the long-term care needs of PWAs.

Opening and expanding the options available to PWAs may yield substantial financial savings. In a three month period we found that there were 304 person days that workers accessed as unnecessary if a less intense setting were available. Conservatively, hospital care in the Chicago area costs $450 per day (Medicaid rates). Assuming that number of days of hospital overstay remain constant throughout the year, $547,200 could be saved, mainly to the state and federal government in the form of medicaid payments for hospitalization. Patient costs would still be required for long-term care, but those costs are estimated to be a quarter to an eighth of hospital expenses.

Conclusions

Response to the long-term care needs of PWAs must be a coordinated effort throughout the care continuum. Federal and state government through their funding agents have a major role in encouraging the development and implementation of reimbursement regulations that will help motivate the industry to provide care. Funding is also needed to continue to educate nursing home personnel and the public at large about the disease and the ways in which it is transmitted.

Discharge planners, for their part, need to become fluent in strategies for advocacy and if necessary, willing to expend the time to file discrimination complaints in order to pressure recalcitrant nursing homes into action. The need for diligent

monitoring and follow-up is critical to educate the long-term care community. Hospitals need guidelines for referral, advocacy, sharing resource lists as well as providing support to their social workers for taking the necessary measures for changing the current situation. Hospitals that treat PWAs and have affiliated nursing homes or skilled units have an obligation to admit PWAs to these units and thus serve as models for the long-term care industry.

The nursing home industry through their trade associations should implement educational and incentive programs for its constituency. Associations should provide experts who have opened their homes to PWAs to consult with their affiliates in order to design responsive systems for the rising demand.

Future studies are needed to explore the attitudes of people with AIDS, their feelings about being placed in nursing homes and what special accommodations should be instituted for them. Nursing home staff, residents and their significant others should be surveyed regarding the impact of PWA admissions to understand and offset pervasive resistance from facility owners. These types of studies are imperative for the development of compassionate policies. It is only through a coordinated effort that is based on a commitment and respect for people with AIDs that a comprehensive model for care can be developed and instituted.

TABLE 1

Chicago Population and Sample Demographic Characteristics

Characteristic	Sample %	Chicago[a] %
Sex		
Male	90	93
Female	10	7
Age		
20 - 29	19	17
30 - 39	55	61
40 - 49	14	15
over 49	12	7
Race		
African-American	43	38
White	38	50
Hispanic	20	11
Risk		
Male to Male Sex	70	69
IV Drug usage	30	15
Other[b]	-0-	16

[a] source: AIDS Chicago, June,1989, Department of Health, City of Chicago

[b] other risks include transfusions, blood products, heterosexual transmission

TABLE 2

Patient Diagnosis and Care Needs

	n[a]	%
Patient Diagnoses		
Pneumocystis carninii	14	33
Wasting syndrome	9	21
Neurological problems	8	19
Kaposi's sarcoma	6	14
Cytomegalovirus	3	7
Candidiasis	3	7
Toxoplasmosis	3	7
Other medical problems[b]	19	45
Care Needs in Hospital		
Nutritional Needs	13	31
I.V. Therapy	12	29
Incontinence Care	12	29
Respiratory Care	7	17
Open Wounds	4	9
Decubitus	3	7
None	11	26

Table 2, continued

	n	%
Patient Orientation		
Alert and Orientated	17	41
Occasionally Confused	15	36
Lethargic	5	12
Consistently Confused	4	10
Unconscious	1	3

a. Total percentage adds up to over 100% as many patients had multiple diagnoses and care needs.

b. Other diagnoses include hepatitis, retinitis, pancreatitis and lymphoma.

TABLE 3

Assessed Level of Care for Discharge and Post-Hospital Outcome

Assessed level of care	n	%
Skilled care facility	15	36
Intermediate care	14	33
Specialized AIDS residence	9	21
Housing	3	7
Patient died before assessment	1	2
Outcome		
Returned home or to home of relative or friend or home with services	10	24
Remained in hospital	9	21
Patient died in hospitaL	8	19
Entered specialized AIDS residence	7	17
Left hospital against medical advice	4	10
Entered residential hotel	3	7
Entered psychiatric hospital	1	2

Table 4
First Placement Attempt and Post-Hospital Outcome

	Outcome							
	Return Home	Remained in Hospital	Died in Hosp.	Entered AIDS Facility	Left A.M.A.	Entered Emerg Shelter	Entered Nursing Home	Total
Type of Facility								
Designated Bed Facility	2	2	2	2	0	0	0	8
Undesignated Bed Facility	1	3	0	0	0	0	0	4
AIDS Facility	2	2	3	5	0	0	0	12

Table 4 continued

First Placement Attempt and Post-Hospital Outcome

	Outcome							
	Return Home	Remained in Hospital	Died in Hosp.	Entered AIDS Facility	Left A.M.A.	Entered Emerg Shelter	Entered Nursing Home	Total
Type of Facility								
Emergency Shelter	0	1	0	0	3	4	0	8
Residential Hotel	0	0	1	0	0	0	0	1

Table 4 continued

First Placement Attempt and Post-Hospital Outcome

	Outcome							
Type of Facility	Return Home	Remained in Hospital	Died in Hosp.	Entered AIDS Facility	Left A.M.A.	Entered Emerg Shelter	Entered Nursing Home	Total
No contact	5	1	2	0	1	0	0	9
Attempt or died before attempt								
Total	10	9	8	7	4	4	0	42

Notes: Marder was a graduate student at the Jane Addams College of Social Work when the study was conducted. Linsk is Associate Professor in the College of Associated Health Professions, University of Illinois at Chicago. The project was a joint effort of the Department of Medical Social Work of the University of Illinois at Chicago, and the long-term care committee of the AIDS Foundation of Chicago. The project was supported by the Department and the Midwest AIDS training and Education Center, Health Resource and Service Administration Grant # BRT-000033-020.

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